STATE OF WASHINGTON

OFFICE OF
INSURANCE COMMISSIONER

REPORT OF

TARGET MARKET CONDUCT EXAMINATION

OF

UNUM LIFE INSURANCE COMPANY OF AMERICA

AT

2211 CONGRESS STREET

PORTLAND, MAINE

AS OF

SEPTEMBER 30, 1997

January 3, 2000

The Honorable Deborah Senn
Insurance Commissioner
Olympia, Washington 98504

Dear Commissioner Senn:

Pursuant to your instructions and in compliance with the statutory requirements of RCW 48.03.010, I have examined the corporate affairs and market conduct of:

UNUM Life Insurance Company of America

Portland, Maine

hereafter referred to as "the Company" or AUNUM@. The following report is respectfully submitted.

Scope of Examination

The examination was performed in compliance with the provisions of Washington insurance laws and regulations. The market conduct review followed the rules and procedures promulgated by the Office of the Insurance Commissioner (OIC) and the National Association of Insurance Commissioners (NAIC). The examination covered the period of January 1, 1995 through September 30, 1997. The scope of this examination was limited to activities concerning the handling of Washington individual long term disability complaints and claims.

TABLE OF CONTENTS

EXAMINATION REPORT CERTIFICATION

This examination was conducted in accordance with the Office of the Insurance Commissioner and National Association of Insurance Commissioners market conduct examination procedures. This examination was performed by Leslie Krier and Mary Cotter. The report was prepared by Leslie Krier.

I certify that the foregoing is the report of the examination, that I have reviewed this report in conjunction with pertinent examination work papers, that this report meets the provisions for such reports prescribed by the Office of the Insurance Commissioner, and that this report is true and correct to the best of my knowledge and belief.

_____

Pamela Martin

Chief Market Conduct Examiner

Office of the Insurance Commissioner

State of Washington

FOREWORD

Throughout the report, where cited, RCW refers to the Revised Code of Washington, and WAC refers to Washington Administrative Code.

SCOPE

TIME FRAME

The examination covered the target company operations from the period January 1, 1995 through September 30, 1997.

MATTERS EXAMINED

The focus of the examination was the life insurance and annuity business, which encompassed the following areas of operations:

- Individual long term disability claims
- Individual and group long term disability complaints

HISTORY OF THE COMPANY

TERRITORY OF OPERATIONS

MANAGEMENT

UNUM Life Insurance Company of America was admitted to the State of Washington August 30, 1971. They are a stock insurance company, are licensed for life and disability insurance in Washington and have authority for variable life and annuity products. Their taxable premium volume in 1997 in the State of Washington was $37,989,123.00. As of the examination date, they had 897 active agents appointed in Washington.

The Company was incorporated on August 24, 1966 and commenced business on September 3, 1966 in Maine. As of the examination date, the Company is licensed to do business in all states except New York as well as holding licenses in the District of Columbia, Puerto Rico and Canada.

The Company is governed by a Board of Directors. The current members are:

James L. Moody
J. Harold Chandler
Thomas R. Watjen
Burton E. Sorensen
Elaine D. Rosen
F. Dean Copeland

COMPLAINTS

The Company has established procedures to handle complaints received from insureds, insurance departments and other entities. How a complaint is handled depends on the type of complaint received.

During the exam period, complaints received on individual policies were routed to the Compliance & Legislative Information Center (CLICK). CLICK has responsibility for coordination of complaint handling but the research, resolution and response is done by the department whose activities are the subject of the complaint.

If a complaint concerns a group policy, the complaint is sent to a special unit in the Group Claims Department. For group policy complaints, the responsibility of researching and responding to complaints rests with the Complaint unit. The complaint is not routed to the unit that paid the claim. The reason for this is that there are six (6) claims offices located throughout the United States. In order to maintain control over the responses, they are handled by a single unit located in the Home Office.

Subsequent Event: Complaint handling procedures have been changed so that all complaints are routed to CLICK where they reviewed, then sent to the responsible department for response.

Per Company records, UNUM received 38 complaints on Individual Disability and Group Long Term Disability policies from Washington policyholders during the examination period. Of these, five (5) complaints were raised to the Appeal level. Four (4) appeals were upheld (denials), and one (1) was overturned (claim was paid).

During the examination, OIC complaint records were reviewed for compliance with WAC 284-30-650 which states that it is an unfair practice for an insurer to fail to respond to any inquiry from the insurance commissioner within 15 business days from receipt of the inquiry. When reviewing complaint records, the examiner used the date the complaint was actually received at UNUM until the actual response date as recorded by UNUM.

There were 28 complaints received by the OIC during the examination period. Of these, one was still open as of the examination date and one was rescinded prior to response from the Company. There were a total of 26 complaints reviewed as part of this examination.

Responses to the OIC on complaints averaged 18 days from the time of receipt at UNUM until the response was mailed by UNUM. This exceeds the 15 days required to comply with WAC 284-30-650.

Response to 4 complaint files exceeded 15 working days. (Appendix I) We also noted that if the OIC required additional information, the company response did not meet the 15 working day requirement.

Eight (8) of the complaints concerned delay of benefit payments due to lengthy investigations prior to payment. Eighteen (18) complaints concerned denial of benefits. There were no complaints for other issues during the examination period.

Standard #1 Insurers are required to respond to inquiries from the insurance commissioner within 15 working days from receipt of the inquiry. WAC 284-30-650

# OIC Complaints	26
# Complaints Reviewed	26
# Complaint Responses > 15 working days	4
% Violating WAC 284-30-650	15% (outside 5% tolerance)

Results: The Company does not meet this standard.

CLAIMS

During the examination period, UNUM processed 220 individual disability claims. This number was provided to the examiners by the Company and was obtained through a search of all company records. Of the 220 claims, 77 were chosen for file review.

During the examination period, the Claims Department was organized by geographical regions. They currently distribute claims evenly to all disability specialists based on claim load. The UNUM claims system tracks the number of claims assigned to each specialist and assigns claims appropriately.

A report entitled ASpecialist Case Plan Report@ is generated from the system showing the status of all claims assigned to each specialist. This report is monitored by management. Action is taken by management as needed based on the information contained in the report. A copy of this report was reviewed as part of the examination process.

Claim notification is received in the Customer Service Unit. A letter with claim forms and instructions about how to file a claim is sent to the claimant immediately. The

Company then follows up on outstanding requirements every 30 days. When the claim form and other proof of loss forms are received at the Home Office, the claim is assigned to a Disability Benefits Specialist (DBS). There are some claim types, such as mental health claims, which are handled by a special unit because of technical knowledge needed to determine disability. Most claims, however, are assigned based on processor claim load.

The claim adjudication process is tailored to each claim, but there are common elements to handling claims. These are outlined in the AIndividual Disability Benefits Guide@. The Company states that this manual is a guideline only and is not considered to be a procedures manual. Most actions on claim files are approved and initialed by a supervisor or manager. The DBS reviews a claim and creates a claim action plan. The action plan includes those reports to be ordered and reviews to take place. Outside investigative tools such as independent medical examinations (IME) or personal visits by field representatives are recommended by management and ordered by the DBS. Monthly checks are approved by management. It is rare that a DBS takes any type of action on a claim independently. Claim files are handled by many people prior to payments being made. Each new piece of information (e.g. APS, IME report) requires a supervisory, or medical director's review prior to further action being taken on the claim. This is a very labor intensive operation.

The Company has a claim audit program. This is not a standardized program, but is risk/control based. The internal audit department conducts the audits which take place on both open and closed claim files. They do not use an audit check list, but do use a test plan and test worksheets to ensure tracking and documentation of audit results. Their test population is chosen specifically to test those areas targeted by the internal audit department. The number of files chosen is based more on the target area rather than a sample based on work from each specialist.

Audit results are reported to management and the board of directors through the Internal Audit Committee of the Board.

Claim Standards

Standard #1 Upon notification of a claim, acknowledge receipt of the claim to the claimant within ten working days. WAC 284-30-360(1) and (4). (See Appendix II)

Company procedure states that a letter of acknowledgment will be sent to the claimant upon receipt of a completed claim form and attending physician statement.

Total Claim Population	220
# Claims in Sample	77
# Claims not acknowledged within 10 days	4

% Sample in violation	5% (within tolerance limits)

Result: The Company meets this standard.

Standard #2 Investigation of a claim shall be completed within 30 days after notification of a claim unless the investigation cannot reasonably be completed within this time frame. WAC 284-30-370 (See Appendix III)

The Individual Benefits Guide does not discuss this requirement. However, it should be noted that many requirements, such as Attending Physician Statements, are not completed within the 30 day time limit. The Company does not have control over receiving information from outside sources, but we do note that they consistently follow up on outstanding requirements.

Total Claim Population	220
# Claims in Sample	77
# Claims not completed within 30 days of notice	41
% Sample in violation	53%

Result: The Company meets this standard where possible. The numbers shown above are due to delays by outside sources. The Company does follow up on the outstanding requests at regular intervals.

Standard #3 Acceptance or denial of a claim must be made within 15 working days after receipt of completed proofs of loss. WAC 284-30-380(1) (Appendix IV)

The Individual Benefit Guide does not discuss this requirement. In

---

reviewing files for this standard, completed proof of loss is defined as receipt of all material requested as part of the adjudication process, such as attending physician statements, financial statements, independent medical examinations, etc. Of the 77 files examined, one (1) file was not complete at the time of examination, therefore was not included in this standard.

Total Claim Population	220
# Claims in Sample	76
# Claims without final action within 15 days	1
% Sample in violation	1.3% (within 5% tolerance)

Result: The Company meets this standard.

Standard #4 Denial of a claim on the basis of a specific policy provision, condition or exclusion must be given to the claimant in writing and the file must contain a copy of the denial notification. Denials for any other reason must be noted in the file. WAC 284-30-380(1) and (2) and WAC 284-30-330(13)

The Individual Disability Benefits Guide, Section II, page 13, describes the procedure to be used when a claim is denied for any reason. This section states that a formal notice must be given to the Claimant showing the actual reason for the denial, and must include specific appeal language.

Of the 77 files examined, seven (7) contained denied benefits. Of these, seven (7) files contained written notice showing the specific reason for denial and included appeal language. Copies of all letters were included in the files.

Total Claim Population	220
# Claims in Sample	77
# Claims without denial letters	0
% Sample in violation	0%

Results: The Company meets this standard.

Standard #5 When a claim determination cannot be made within 15 working days of receipt of completed proof of loss, notification must be given to the claimant within the 15 day time limit, and each 30 days thereafter. Notification must contain the reason for the delay in the investigation. WAC 284-30-380(3) (Appendix V)

The Individual Disability Benefits Guide does not contain specific

---

procedures to meet this standard. The Company provided copies of pages from their on-line, state specific compliance manual that includes correct Washington requirements.

Subsequent Event: In 1997, the Company created a booklet titled "Service Standards" that contains written standards for claim handling. One standard states "100% of all claimants shall received written updates on the status of their claim every three weeks before acceptance/denial."

Seventy-seven (77) claim files were examined to determine if UNUM consistently communicates status to the claimant during the adjudication process. Twenty-four (24) files were found to have a final determination prior to the 45th day after receipt of the completed proof of loss. These were eliminated from the sample.

Of the remaining 53 files, 40 contained evidence that consistent status notification was communicated to the claimant at least every 30 days. The remaining 13 claim files did

not have documentation of status notification within the 30-day time frame stipulated in this regulation.

Total Claim Population	220
# Claims in Sample	77
# Claims without final determination at 45th day	53
# Claims without status notification after 45th day	13
% Sample in violation	24.5% (Outside 5% tolerance)

Results: The Company does not meet this standard.

Standard #6 Claim files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed. WAC 284-30-340 (Appendix VI)

The Individual Disability Benefits Guide, Section II, page 28, details the type of information required to document files. This section is explicit, and explains that all actions much be documented impartially and completely.

In reviewing the claim files, we found that files were missing pertinent documentation. The information showing how a settlement offer is calculated was not routinely added to the file until after discussions took place with the claimant. At that point, the offer meeting was documented, but how the offer was arrived at was not. Settlement offers are presented by a field representative who does not have access to the file. It is especially important to document the details of the calculation of the settlement offer in the permanent file.

Of the 77 files examined, the paperwork does document the major activities and decisions in 73 files, while settlement offer documentation was missing from four (4) files.

Total Claim Population	220
# Claims in Sample	77
# Claims files not fully documented	4
% Sample in violation	5% (Within 5% tolerance)

Results: The Company meets this standard.

Standard #7 If claim payments are made without a final determination on the claim, the company must advise the claimant of possible reimbursement in writing. WAC 284-30-350(7) (Appendix VII)

The policies examined allowed for payment of claim prior to final determination of liability. The policies also allow the Company to recover payments made prior to final determination if the final determination is to decline the claim. This process is called Payment with Reservation of Rights (ROR). The letter sent with an ROR payment does not state that the claimant may have to reimburse the Company if the final determination is denial.

The Company states that "*it is UNUM's practice not to seek reimbursement of ROR payments. We reserve the right to determine benefit eligibility at a later date, but we do not attempt to reserve the right to reclaim benefits paid.*." The Company needs to declare their contractual right of recovery in the ROR letter, or the company must change the policy language to reflect their actual practices.

Total Claim Population	220
# Claims in Sample	77
# Claims Paid with ROR	4
# Incomplete disclosure in Letters or No Letter Sent	4
% Sample in violation	100% (Outside tolerance level)

Results: The Company does not meet this standard.

Standard #8 Reasonable standards have been adopted to ensure prompt payment of claims once the obligation to pay has been established. WAC 284-30-330(16)

There are no formal procedures or standards to ensure prompt payment once liability has been established. However, the examiners' file review did not uncover any instances of lengthy delay in payments.

Subsequent Event: In 1997, the Company adopted Standards of Service which do include specific standards for prompt payment.

Results: For most of the exam period, UNUM did not have written standards for prompt payment of claims. However, we did not find any payment delays in the files reviewed. Given that they did develop and distribute standards during the last year of the exam, the Company meets this standard.

Standard #9 Adopt and implement reasonable standards for the prompt investigation of claims. WAC 284-30-330(3)

The Company has a manual entitled "Individual Disability Benefits Guide." This manual discusses the basic procedures and company philosophy for adjudicating individual disability claims, but does not set standards or formal procedures for the claim process. The manual contains suggestions and ideas on how to process claims and has some

directives about who must see the file before final determination, but does not set steps to take when working on a claim. The manual encourages the DBS to tailor the claim process to the individual claim.

In 1997, the Company published "Service Standards" which is a booklet that shows the standards to which agents and employees will be held. One section of this booklet is titled "Performance Standards/Disability Coverage." This section describes standards for new case administration, customer service responsiveness and claims administration. It does include standards for the areas covered by Washington regulations.

Results: The Company meets this standard

Standard #10 An investigation or payment of claim may not be delayed by requiring a claimant or physician to submit preliminary claim forms and subsequently requiring additional submissions of substantially the same information. WAC 284-30-330(11)

Once a claim has been approved, the claimant and physician are required to submit monthly progress statements unless the claim is determined to be a short term claim with a definite return to work date (closed period claim). A closed period claim is paid through the return to work date and then closed. If the claimant does not return to work, the claim is reopened and more investigative work is done.

The Company requires monthly progress statements for open period claims. There are complaints in files from claimants and physicians pertaining to the monthly statement requirement and redundancy of the information required. When it is determined that a claim will run indefinitely, the claim is put on special handling or reduced handling status. This requires progress statements on a less frequent basis. However, the Individual Disability Benefit Guide manual states that this cannot occur until the claim has been open for at least 12 months.

In the claim files reviewed, there were occasional instances where the DBS would request duplicate medical or financial information. However, this does not appear to be standard practice, but rather an error on the part of the DBS caused by poor file documentation or a lack of understanding on the part of the DBS as to the information required in order to make a final determination.

Results: The Company meets this standard.

INSTRUCTIONS

1. The Company did not meet the requirements of WAC 284-50-650, which requires an insurer to respond to inquiries from the Office of the Insurance Commissioner within 15 working days of receipt of the inquiry. **The Company is instructed to adhere to the 15 working day standard when responding to OIC inquiries.** (Page 7, Complaint Standard #1, Appendix I)

2. WAC 284-30-380(3) requires that notification of delays in claim processing, including the reason for the delay, must be given to the claimant every 30 days. The Company did not regularly communicate with the claimant as to status of the pending claim in 13 files. **The Company is instructed to add a procedure to the Individual Disability Benefits Guide showing when status notification is required, and to add this requirement to their quality audit procedure to ensure compliance.** (Page 10, Claim Standard #5, Appendix V)

3. WAC 284-30-350(7) requires that any payment made before final claim determination (Reservation of Rights payments) be accompanied by a letter that states there is a possibility that the payment(s) may need to be reimbursed to the insurer. The Reservation of Rights letter used by the Company does not disclose this policy provision. **The Company is instructed to revise the Reservation of Rights letter immediately to include the required disclosure, or to amend the policies to remove the company's right to recover benefits paid out prior to the final claim determination.** (Page 12, Claims Standard #7, Appendix VII)

RECOMMENDATIONS

1. WAC 284-30-360(1) and (4) require a Company to acknowledge receipt of claim notification within 10 working days of notification of the claim. The Company should ensure that acknowledgment of all claim notification occurs as required. (Page 9, Claim Standard #1, Appendix II)

2. WAC 284-30-340 requires that claim files contain all notes and work papers pertaining to the claim. Our review found that 4 files contained missing documentation. While this is within the tolerance level established for this examination, we recommend that the company ensure that all documentation is available in the claim file, including details related to the calculation of settlement amounts. (Page 11, Claim Standard #6, Appendix VI)

APPENDIX I

COMPLAINT STANDARD #1

Complainant	# Days for 1st Response	# Days 2nd Response
Floyd	40	n/a
Karim	35	n/a
Britton	34	n/a
Dunker	70	n/a

Note: The policies listed in this chart represent those complaints that did not meet the 15 working day requirement established in WAC 284-30-650

APPENDIX II

CLAIMS STANDARD #1

The following policies did not contain evidence that the Company acknowledged receipt of the claim within 10 working days:

CLA 962259

CLA 961406

CLA 963090

CLA 972103

APPENDIX III

CLAIMS STANDARD #2

The following claim investigations were not completed within 30 days after notification of the claim:

CLA 961406	CLA 951617	CLA 951618
CLA 860799	CLA 971931	CLA 942361
CLU 940262	CLA 952380	CLA 960873
CLA 941519	CLA 972103	CLA 941182
CLA 940865	CLA 940283	CLA 941284
CLA 950860	CLA 830022	CLA 800304
CLA 970063	CLU 950402	CLA 971410
CLA 951129	CLA 932828	CLA 940141
CLA 962193	CLA 890192	CLA 972152
CLA 950697	CLA 931516	CLU 940340
CLA 851731	CLA 920315	CLA 953059
CLA 951489	CLA 951490	CLA 910889
CLA 942591	CLA 851383	CLA 952609
CLA 952611	CLA 952614	

APPENDIX IV

CLAIMS STANDARD #3

The following claim files did not contain evidence that acceptance or denial of a claim was made within 15 working days after receiving completed proof of loss documents:

CLA 860799

APPENDIX V

CLAIMS STANDARD #5

The following claim files did not contain copies of communications with the claimant regarding notification of delay in processing a claim:

CLA 842719

CLA 842720

CLA 941519

CLA 941182

CLA 940865

CLA 951129

CLU 930320

CLA 931516

CLA 851731

CLA 953059

CLA 952609

CLA 952611

CLA 952614

APPENDIX VI

CLAIMS STANDARD #6

The following claim files did not contain complete documentation:

CLA 942361

CLU 940262

CLA 940141

CLA 963057

APPENDIX VII

CLAIMS STANDARD #7

The following claim files contained Reservation of Rights (ROR) letters that omitted the statement that the claimant may have to reimburse the Company if the final determination is denial.

CLA 83022

CLA 920315

CLA 962210

CLA 941284